# Mental Health Services Of Catawba County

Draft Local Business Plan

April 1, 2003

## Section IV. Service Management

Contact Person:
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# Local Business Plan: Strategic Plan Matrix

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| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The interface between the DHHS-developed information and assistance program and any internal screening processes.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| We currently interface with the state help-line and are tied into the state's systems.<br><br>Access services are detailed in the Access sub-section and emergency services are available 24/7 | Will assure that all systems of consumer access and contact are compatible, with data tracking to assure timeliness and referral outcomes consistent with state guidelines. | The state has not made public sufficient information on the DHHS developed information and assistance program to permit full implementation of this. |

**Reviewers Comments:**

# Local Business Plan: Strategic Plan Matrix

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| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The accessibility and availability of screening services.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| We currently have a centralized Access system in place with multiple points of direct referral and several independent entry points throughout the community.<br><br>Information is gathered by phone or in person, allowing assessment referral to be initiated based on clinical priority of the presenting problem (urgent, emergent, routine)<br><br>During regular business hours, Access staff see urgent cases on-site or at the client's location if indicated, and/or facilitate arrangements for that face-to-face contact. 24/7 Emergency Services are available after business hours, centralized through the local 911 system. Specialized services (e.g., interpreters, transportation accommodations, etc.) are initiated with Access. | Work with Access committee in developing staff qualifications and privileging requirements for Access uniform portal requirements (i.e., level of education and clinical experience, familiarity with cross-disability issues and presentations, etc.)<br><br>Make sure all independent entry points are staffed with qualified professionals, concurrent with adequate supervision process<br><br>Do collaborative training efforts with staff located at all entry sites (i.e., program staff and facility-based staff),assuring consistency and reliability of information gathered and used for referral | Lack of funding to staff multiple entry points, provide comprehensive training and supervision |

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| **Reviewers Comments:** |
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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The accessibility and availability of assessment

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Based on clear indication of MH/DD/SA need, Access staff have capacity to conduct cross-disability assessment of presenting problem and refer for clinical assessment.<br><br>Clinical assessments are done by qualified staff/providers within the timelines established by the state, based on clinical data directing referral as urgent, emergent or routine.<br><br>Assessments are completed by staff who match client choice, have expertise in client's presenting problem area for diagnosis and treatment recommendations, and who can provide information necessary for determining target population eligibility.<br><br>Based on clinical assessment outcome, specialized assessment (e.g., psychiatric evaluations, | Continue coordination of efforts with Access team and QPN team to ensure consistent availability of assessment services.<br><br>Ensure continued integration of assessment services with therapeutic and other services.<br><br>Ensure all levels of assessment (Access, clinical assessment and specialized assessments) will be timely, utilize best practice methodology, and produce results to be incorporated in overall service/ treatment planning | |

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| psychological testing, etc.) will be authorized and made available as clinically indicated. | | |

| **Reviewers Comments:** |
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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The capacity for referral and development of community referral networks as well as the utilization of existing referral network.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Access has extensive experience in use of a referral system, primarily to internal providers (area program staff). Access is familiar with matching provider with client need, assuring timely referral appointments and assessment of interim needs between access call (entry into the system) and treatment contact.<br><br>Currently 26.9% of services are contracted out, with referral systems in place<br><br>QPN committee has done a data analysis of current client populations and service needs. This information has been used in identification of service providers in the community and to identify gaps needing to be addressed in the QPN base. Service units per population have also been used in anticipating/ developing divestiture plans for services, strengthening referral capacity and clarity. | Use data from referral tracking systems to identify any service gaps, any areas requiring a concentration of interim services (prioritizing them, then, for QPN development), frequency of use of specialized services, and coordinating with other neighboring programs to provide services from their network.<br><br>Make sure all referrals are seamless<br><br>With collaborative efforts, continue to solicit and build community networks to meet needs, especially in supports (e.g., transportation, housing, etc.) that are not necessarily clinical but meet comprehensive service needs. | Community resources are dwindling with the struggling economy and loss of revenues. Lack of financial incentives to build resources. |

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| Data is available on all referrals (timeliness, availability, scope of services, etc.) | | |

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| **Reviewers Comments:** |

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The availability of services and supports for non-target populations.
- Memoranda of agreement (MOAs) or other types of agreements between and among community agencies/organizations to enhance the availability of services/supports to non-target populations.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Examined active clients in program, determining that most individuals in the non-target population are currently receiving services primarily through outpatient therapy and psychiatric care<br><br>Identified those community services currently providing services for non-target populations and their capacity for outpatient services, particularly churches, EAP programs, Women's Resource Center, Family Guidance, family physicians. These resources are in addition to service capacity for those clients with insurance and/or other funding streams.<br><br>Agency staff participate in the Non-profit Interagency Council on a monthly basis. This | Look for methods to increase community capacity for services and supports to non-target populations.<br><br>Through clinical transitioning, encourage current outpatient staff to be aware of supports (systemic and client-specific) which are utilized, working with Collaboration, QPN, Access, and Service Management committees to identify community strengths in this area and establish more formal links with these resources<br><br>Detail current emergency funds utilized in area program (e.g., FEMA funds, Caring and Sharing funds set aside for supports, sponsorship funds set aside for services, etc.) and explore the possibility of designating a percentage to go to community | Community resources are currently used as referral sources to full capacity. Lack of funding and incentives make it difficult to increase capacity or bring in new or expanded resources |

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| organization brings together the community agencies and non-profits for sharing and collaboration. Program information and referral information is shared to ensure non-duplication of services and to determine services gaps for the community.<br><br>Identified community supports such as Salvation Army, Cooperative Christian Ministries, school programs, support groups such as NA/AA and other self-help groups. Intensified collaborative efforts with these organizations.<br><br>Have discussed with potential providers the need for services to non-target populations, with education on who falls into that category<br><br>Have begun more referrals into the community for those individuals who do not meet target-population eligibility.<br><br>Have begun addressing transition issues with staff regarding current caseloads and aggressively building in natural supports and other community supports for those clients no longer prioritized for services by being in a target population category. | resources to help build supports/capacity<br><br>Continue active collaboration within the community, particularly in prevention efforts with support groups, which may keep non-targets from decompensating symptomatically or functionally – addressing such issues as family roles, relationship issues, anger and stress management, etc.<br><br>Develop MOAs as indicated<br><br>Maintain active role with Access and QPN, particularly around effective and satisfactory referrals to community resources/supports available for non-targets. Track data and make improvements as indicated | |

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The policies for service coordination throughout the geographical region served by the LME.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| The Service Coordination Policy has been revised and approved by the Quality Management Team (Attachment A)<br><br>Elements of service coordination that are related to access to services in a timely, efficient and appropriate manner are addressed in the Access section of the LBP.<br><br>Elements of service coordination that are related to collaboration between the different agencies and service providers are addressed in the Collaboration section of the LBP.<br><br>Elements of service coordination that are related to the QPN are addressed in the Access and QPN sections of the LBP. | | |

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| **Reviewers Comments:** |
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**Attachment A – Service Coordination Policy**

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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|---|---|---|
| ACTIVITY: CLINICAL SERVICES | Number: | 3.001(a) |
| | Effective Date: | 10/14/98 |
| SUBJECT: SERVICE COORDINATION | Amended Effective: | |
| | Board Approved: | N/A |
| | QMT Approved: | 02/14/03 |

PURPOSE:

Mental Health Services of Catawba County (MHSCC) recognizes that the best practice models for human service delivery all focus significantly on service coordination. Consumers of services must not only expect appropriate and timely services, but must expect complete, professional communication and coordination between different service providers. Careful service coordination serves to protect consumers from costly service duplication as well as from services that may conflict in purposes and goals.

POLICY:

It shall be the policy of MHSCC to ensure, at every level of service decision or delivery, that careful and effective coordination of services takes place. This coordination shall be applied to both area-operated services (intra-agency) and those services between the Area Program and private or contracted services (inter-agency). MHSCC is committed to the development of a strong and seamless network of supports and services while increasing community awareness of the benefits of services. The agency is further committed to development of a supportive relationship with consumers and families, the Qualified Provider Network, and community partners at large to promote services and supports that are consumer-driven and culturally competent.

PROCEDURE:

1. The Area Program will develop, implement, and continually revise policies and procedures relative to care processes that impact service coordination. These policies shall address admissions, discharges, intake and access, referrals, and major contractual agreements such as with schools, hospitals, courts, etc.

2. At every level of treatment planning and review, the needs and preferences of consumers will be addressed to insure that services are not duplicative, unnecessarily costly, or in conflict of purpose or goals.

3. Agency staff shall participate in all relevant interagency and community treatment planning groups.

4. Consumers are provided choices in the clinical services they receive, as well as the providers of those services whenever it is possible given the needs of the consumer. These choices will include a choice of support and service coordinators, a choice of case managers, and a choice of service locations as appropriate and available.

5. The management of the agency will conduct an annual assessment of progress in the completion of strategies and interventions for increasing capacity for services and supports in the coordination of the services available to consumers.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

ACTIVITY: CLINICAL SERVICES SUBJECT: SERVICE COORDINATION__

EFFECTIVE DATE: 10/14/98 AMENDED EFFECTIVE: N/A NUMBER: 3.001(a)

HISTORY NOTE:

Policy 1.002 (Mission Statement, Philosophy and Principles), 1.015 (Interagency Community Relations), 1.025 (Admissions – General), 1.025a (Discharges – General), 3.003a (Referrals), 3.003b (Intake/Access), 3.003(e)(2) (Agreement with Local Schools), 3.003b (Inpatient Hospitalization). AMT approved 10/14/98. QMT 02/14/03.

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The role of consumers/families and other stakeholders in developing and monitoring the core service functions.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| CFAC has been established and is fully functional, with policy reflecting defined roles and responsibilities<br><br>Community/stakeholder forums have been held to educate on MH Reform, including the proposed LME core function roles | Create mechanisms for consumer and family involvement in monitoring of core service functions<br><br>Assure that all stakeholders are represented in supplying feedback on core service functions. Make opportunities for input reflective of community stakeholder makeup, including language accommodations for Spanish and Hmong and hearing impaired<br><br>Explore existing Transitional Employment (TE) specifications and determine how roles can be expanded to include involvement in planning/development/monitoring committees for those consumers involved in the TE program | Limitations to consumer participation due to consumer time constraints (e.g., other jobs, family roles, etc.), transportation, etc.<br><br>Amount of time required to train consumers to be part of a monitoring process to maximize their involvement |

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- The services and supports identified to increase the effectiveness and efficiency of community resources.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Care coordination and client-specific case management functions have been identified as methods to assess and report system effectiveness of service provision (success in meeting client goals, treatment outcomes through best practice delivery, client satisfaction, provision of complete service array, etc.) Efficiency can be monitored and measured by non-duplicative interventions for clients.<br><br>The direct oversight of other efficiency measures -- competitive bidding, economies of scale, shared and/or collaborative efforts in service provision like sharing vans for transportation, etc., overall cost-effectiveness – are the responsibility of the Service Management Committee in conjunction with QA/QI department | Collaborate with community providers to develop a baseline of agreed-upon expectations regarding efficiency and effectiveness of community resources, both aggregately and client-specific<br><br>In oversight function, include feedback from both clients and service providers, making sure that there is a seamless array of service provision<br><br>Maintain collaborative efforts with community supports, providing assistance and cooperation in identifying systemic processes that are working well or needing revision.<br><br>Seek further clarification of efficiency and effectiveness expectations from MH/DD/SA so that requirements are met to the fullest extent possible | |

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
- Description of outreach efforts to identify those at risk of becoming members of target populations
-Prevention efforts that are collaborative and address universal prevention.
- Demonstration efforts at collaboration around shared populations, including but not limited to schools, detention centers, Departments of Social Services (DSS) and rehabilitation facilities.
- The types of innovative education and information efforts that are being pursued both to enhance prevention of disability and reduce the need for more intense services.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Outreach and preventive efforts to identify those at risk of becoming members of target population are in place and include the following:<br><br>Linkage with Adult Protective Services to educate staff on recognizing characteristics indicative of mental health concerns<br><br>Regular contact with Catawba County Sheriff's Department around issues related to mental illness and substance abuse. Screenings are available on-site.<br><br>Consultation with childcare educators working with children ages 0-5 regarding concerns noted with any | Continue outreach, prevention and collaborative efforts.<br><br>Continue to identify ways in which universal prevention efforts can be implemented. | Lack of funding model makes it difficult to plan for allocation of resources to address this issue |

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| specific child and provision of technical assistance in development of interventions and classroom goals for that child in conjunction with the family. Staff education workshops and parent skill-building workshops are provided.<br><br>Collaboration with Adult Care Home staff to educate on broad mental health issues and recognizing characteristics indicative of mental health concerns<br><br>Outreach of our EAP coordinator to industry with education on mental health effects in the workplace, prevention and wellness programs.<br><br>Participation in health and community resource fairs providing information on mental health issues and access to service information.<br><br>The Steppin' Up program in the school systems and housing projects focuses on alcohol, drug and tobacco prevention efforts for children ages 6-14. The program involves a science-based curriculum and is outcome based.<br><br>Totally Teens Health Clinic was developed by Catawba County Public Health to address teen health issues and Mental Health Services of Catawba County provides support around the mental health needs of teens<br><br>Work First QSAP involves collaboration with DSS to complete assessments on individuals potentially at risk of substance abuse<br><br>Collaborative effort with the school systems to intervene with children at risk of suspension due to | | |

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| behavior problems<br><br>Series of presentations at senior centers on wellness and mental health<br><br>Education provided for general public to distribute information on mental health, wellness, stress reduction, etc.<br><br>Newspaper articles, radio announcements, participation in local radio talk show are regularly provided to educate the public.<br><br>Smart Start collaborative effort with DSS and Public Health through the development of a multi-disciplinary, multi-agency team to provide consultation, education, and screening for children 0-5 years of age and their families with the goal of preparing children for school readiness.<br><br>Early intervention consortium with ECIS, PH and DEC to ensure children with developmental delays/disabilities are able to access services.<br><br>Single Portal process in place with data tracking capability to identify the needs in the community for developmentally disabled individuals.<br><br>Collaborative efforts with Benfield and Podger Associates around Traumatic Brain Injury (TBI) training and TBI support group for TBI consumers and their families. | | |

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| New Beginnings, which is an advocacy group organized by consumers at the Connections Clubhouse, provides education around mental health issues for their SPMI peers. | | |
| **Reviewers Comments:** | | |

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1a**

**Goal: A management plan for oversight and operation of core service functions is attached and addresses:**
**-** The policies and procedures for the provision of emergency services including:
24-hour triage
The constellation of services/supports/treatments available 24/7
The accessibility of these services in terms of both location and physical and programmatic access.
Public awareness of the local community response system.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Emergency Services policies and procedures are in place. (Attachment B)<br><br>24/7 Emergency Services are available after business hours, centralized through the local 911 system. Phone contact is employed most often in assessing the client needs, but face-to-face assessments are done at local hospital ERs for more urgent demands.<br><br>During regular business hours, Access staff see emergent cases on-site or at the client's location if indicated, and/or facilitate arrangements for that face-to-face assessment contact. | Continue integration of Emergency Services with Access and the public health care entities, maximizing personnel resources available on a 24/7 basis with associated supervisory oversight<br><br>Continue work with the local ERs around after-hours crisis services.<br><br>Per CFAC recommendation, develop additional crisis bed capacity and a consumer run drop-in center. | Lack of funding model makes it difficult to know what resources can or should be allocated to the after-hours emergency response team |

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| 24/7 clinical coverage has the capacity to handle all levels of MH intervention, from consultation to commitment proceedings.<br><br>ACT team in place to provide emergency coverage for their assigned cases<br><br>Public awareness of Mental Health Service access (including Emergency Services) is publicized on the local government TV channel, at schools, in libraries, government offices and other public access locations. Additionally, access information is advertised under multiple headings in the phone book and on local radio stations | | |

| **Reviewers Comments:** |
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**Attachment B – Provision of Services Policy**

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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|---|---|---|
| ACTIVITY: CLINICAL SERVICES | Number: | 3.001 |
| | Effective Date: | 01/07/82 |
| SUBJECT: PROVISION OF SERVICES | Amended Effective: | 10/27/00 |
| | Board Approved: | 01/12/95 |
| | QMT Approved: | 02/14/03 |

POLICY:

The Mental Health Services of Catawba County (MHSCC) Board will assure the delivery of a reasonable and appropriate set of services for those Catawba residents who are mentally ill, developmentally disabled, or who deal with substance abuse issues. These services will be provided by professionals who are credentialed and privileged. These professionals will have received training and/or will be licensed, or supervised by a licensed professional to perform the duties determined by job descriptions. Services shall be provided either through direct operation or by contract with other service providers within the community.

PROCEDURE:

The following services are seen as the minimal level of activity necessary to meet basic service requirements:

1. Consultation and education services will be provided to the general public, public schools, private interest groups, and other service agencies for the purpose of general information, increased awareness of unmet needs, specific information, accessibility to local and state facilities, increased skill, methods of prevention, and greater understanding and knowledge about developmental disabilities, mental health, and substance abuse. We intend to serve and make information available through translated materials to the community's major cultural sub-groups by securing translated materials as they become available, along with translating our own materials.

2. Twenty-four-hour emergency services will be provided to all citizens regardless of age or disability who are experiencing emotional and mental crises. This includes access to a qualified professional seven days a week, twenty-four hours per day.

3. Outpatient services will be made available at a minimum of 40 hours per week to adults, children, and families who experience conditions related to mental illness, developmental disabilities, and substance abuse. Hours of service availability shall be flexible and include evening hours. Consumers will be provided a choice of clinicians from whom they may receive services whenever this is possible given the treatment needs of the consumer.

4. Psychosocial rehabilitation shall be available a minimum of four hours per 24-hour period for five days per week. These services will be oriented to adults with mental and emotional disorders who require more treatment intensity than outpatient services but less than inpatient hospitalization.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

ACTIVITY: CLINICAL SERVICES SUBJECT: PROVISION OF SERVICES

EFFECTIVE DATE:01/07/82 AMENDED EFFECTIVE: 10/27/00 NUMBER: 3.001

5. Case management services will be provided for individuals of all disability groups who need coordination and planning of services. It may include advocacy on behalf of the client and/or facilitating and monitoring services that may be provided by area program staff or by other professionals in the community where the client resides. Whenever possible, given the needs of the consumer, consumers will be provided a choice in who their case manager will be.

6. Inpatient psychiatric and detoxification services will be provided through a contract agreement with a local general hospital and by referral to state facilities. These inpatient services shall be for both adults and children who need the intense medical and physical supervision that can be provided through inpatient services.

7. Aftercare/follow-up services will be provided to people who have been hospitalized either locally or in State facilities. This includes the identification of developmentally disabled individuals who live within the community and making their legally responsible person aware of available services.

8. Information, screenings, and referrals will be given to all persons who require services beyond the capacity/scope of MHSCC programs. In order to facilitate access and referral, MHSCC Services will maintain updated information about other Mental Health, Developmental Disabilities, and Substance Abuse services in the area, region and state.

9. Single-portal of entry/exit services will be provided to insure appropriate local screening and referral to state facilities, involvement in state facility treatment plans, and community aftercare.

10. Non-hospital, medically supervised detoxification services will be provided through a contract agreement to individuals who are in need of alcohol or drug detoxification, but who do not need the level of medical attention necessary with inpatient detoxification.

11. Alcohol and drug education traffic schools (ADETS) and Drug Education Schools (DES) will be provided in accordance with state law.

12. Developmental day services will be provided by area program staff or through a contract agency for special education needs.

13. Adult developmental activity services for substantially developmentally disabled and physically handicapped adults will be provided by area program staff and through a contract with a non-profit sheltered workshop.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

ACTIVITY: CLINICAL SERVICES SUBJECT: PROVISION OF SERVICES

EFFECTIVE DATE:01/07/82 AMENDED EFFECTIVE: 10/27/00 NUMBER: 3.001

14. Forensic screening and evaluations will be provided to offenders and alleged offenders who are referred through the criminal justice system. Consultation to law enforcement officials will be provided regarding, but not limited to, commitment of an offender or alleged offender to any state hospital.

15. Early Childhood Intervention Services will be provided to promote the developmental growth of preschool children who are at high risk or who have developmental disabilities or delays. Support will be provided for families regarding child development skills and management. A comprehensive assessment addressing the needs of the children will be provided on a regularly scheduled basis.

HISTORY NOTE: 10 NCAC 15A .0115- .0127 (revised effective 07/01/96). G.S. 143B-147, APSNM 30-1, Section .0500. Effective date 01/07/82. Approved by the Mental Health Board on 01/07/82. Amended effective 01/12/95, 10/14/98, and 10/27/00. QMT approved 02/14/03.

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| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 1b**

**Goal: The core functions management plan is supported by the CFAC, or a report of issues/concerns is submitted along with an action plan jointly employed by the LME and the CFAC**.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| CFAC has been involved in planning and aware of the agency's decision making at each step of the process in local business planning<br><br>CFAC has been responsive to requests for information and input from consumers and other stakeholders.<br><br>Plan was taken to CFAC for review and comments | Continue involvement of CFAC in planning and review | |

**Reviewers Comments:**

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| **Submission Date** | 04/01/03 |
| | |

**Item: IV. Service Management 1c**

**Goal: The LME indicates a capacity to provide disaster response and recovery activities that are service area wide and addresses disaster preparedness planning, response and recovery on a county-by county basis. The LME demonstrates coordination with other agencies and organizations in these efforts.**

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Mental Health Services of Catawba County adheres to the Catawba County Multi-Hazard Plan including evacuation procedures, bomb threats, civil disturbances, elevator emergencies, explosions, natural disasters, fire, medical emergencies, toxic spill, etc.<br><br>In addition, the MHSCC Emergency Action and Fire Prevention Plan covers scenarios specifically related to dealing with our specialized population and facilities. This includes fire drills, bomb threats, | Continue to monitor and revise the disaster preparedness plan as needed.<br><br>Coordinate with Catawba County Sheriff's Department around homeland security issues | |

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| natural disasters, medical emergencies, assaultive consumers, etc.<br><br>Critical Incident Stress Management team is functional and includes individuals from law enforcement, DSS, EMS, faith based community. Their deployment is integrated with the Catawba County disaster preparedness plan | | |

| **Reviewers Comments:** |
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| |

# Local Business Plan: Strategic Plan Matrix

| | |
|---|---|
| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 2**

**Goal: The local business plan describes how the LME will conduct service authorization within state standards, including the following:**
- Method of service authorization for each service, including decision making criteria.
- Methodology that ensures services are not delayed by the authorization process.
- How service authorization relates to claims management to assure that unauthorized services are not paid, and claims management does not reject authorized services.
- How the service authorization process addresses person-centered planning mechanisms.
- How service authorization consistently promotes models of best practice.
- Mechanisms to ensure that consumers/families have the ability to resolve differences or disputes between person-centered planning outcomes and service authorization decisions.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| Currently have a Utilization Management process in place to handle requests for services. If contract services are requested (e.g., CBS, residential services, respite, ADVP), authorizations are evaluated and granted based on the Division's Level of Care document and medical necessity. Requests for authorization are handled immediately in emergency situations, or completed within 5 working days for routine requests. Based on review timelines mandated per Level of Care, cases are reviewed for continued authorization by looking at treatment plan goals and progress, assuring person-centered | Reorganize LME staff to accommodate Utilization Management demands required with an expanded Qualified Provider Network | Provider network not fully developed or operational at this time.<br><br>Grievance process may not be as expedient as desired if consumer speaks a different language which requires scheduling of interpreters through all levels of appeal |

| | | |
|---|---|---|
| planning and best practice interventions, and treatment outcomes. Client choice also plays a primary role in consideration for selection of service provider.<br><br>Contractual language and client-specific addendums reflecting authorized units of service assure that unauthorized services are not paid and claims management does not reject authorized services, as invoices are matched against contract specifications. Finance Department tracks on invoice and authorization matching, along with payment.<br><br>Complaint/Grievance procedure provides mechanism for presenting and addressing consumer complaints (Attachment C)<br><br>Clients/consumers/families are informed of their rights upon admission, particularly regarding their right to exercise the complaint/grievance process. This also includes education on the Medicaid appeals process, to which the area program adheres.<br><br>Client Rights Committee is in place and functional, with active participation from all disability areas; should complaint process advance to a formal grievance, review by this committee is the final step in complaint/grievance procedure. | | |

| **Reviewers Comments:** |
|---|
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**Attachment C – Complaint/ Grievance Procedure**

Attachment C – Complaint/Grievance Procedures – Service Management
Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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| | | |
|---|---|---|
| ACTIVITY: CLIENT RIGHTS | Number: | 5.001s |
| | Effective Date: | 05/07/92 |
| | Amended Effective: | 10/27/00 |
| SUBJECT: COMPLAINT/GRIEVANCE | CRC Approved: | 03/20/00 |
| PROCEDURES | Board Approved: | 04/ 04/00 |
| | QMT Approved: | 10/27/00 |

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POLICY:

The Mental Health Services of Catawba County (MHSCC) Board and staff members shall insure that any client receiving services in any area operated or contracted program will have access to proper procedures to address complaints about services received. Client complaints are viewed as a viable source of information not only to resolve individual client problems, but to assist in the planning and delivery of services by the area program.

All staff members at MHSCC are directed to respond to and act upon all complaints from clients, their family members and/or guardians, staff persons and community members in a polite, helpful, and expeditious manner. In all circumstances, this must involve judgment on the part of each employee.

All formal complaints will be processed in an expeditious manner and the confidentiality of persons served will be protected at each stage of the process. Responses to formal complaints shall be documented and patterns or trends analyzed and reported to the Quality Management Team in order to continually improve the quality in service provision.

PROCEDURE:

Definitions:

Formal Complaint: Any complaint that has not been resolved at the initial point of contact between the client and staff of MHSCC, with the client having agreed to put the complaint in writing.

Grievance: Any complaint that the client feels has not been resolved to his/her satisfaction after following the procedure below.

The following steps are provided to address client complaints about services:

Attachment C – Complaint/Grievance Procedures – Service Management

Mental Health Services of Catawba County

**Policies and Procedures**

ACTIVITY:CLIENTS RIGHTS SUBJECT: COMPLAINT/GRIEVANCE

EFFECTIVE DATE: 05/07/92 AMENDED DATE:10/27/00 NUMBER: 5.00ls

**I. Complaint Process**

A. If a client's problem is unresolved after talking with the staff member assigned to provide the service or the Client Rights Coordinator (if the client does not feel comfortable addressing the staff directly), the client will be asked to complete Part 1 (Attachment A) of the Client Complaint Form. All necessary accommodations will be available to the client to assist in the completion of the form. The client will be given a copy of the procedure for processing a complaint as well as filing a grievance. Upon completion of the form, it will be forwarded to the Client Rights Coordinator to be logged for tracking purposes. The staff member initially involved with the complaint will make a verbal notification to his/her supervisor regarding the complaint. The staff member should also give the client the name and number of his/her supervisor. The Client Rights Coordinator will forward the form to the appropriate supervisor within five working days.

1. The supervisor (or designee) will contact the client within five working days of receiving Part I of the Client Complaint Form.
2. The supervisor will listen to the client's concerns and requests for action. The supervisor will investigate the facts of the situation and evaluate both the employee's and client's points of view.
3. After a discussion with the client regarding the complaint, the supervisor will complete Client Complaint Form - Part 2 (Attachment B) in the appropriate place.
4. If resolution is achieved, the Client Complaint Forms Part 1 and 2 should be forwarded to the Client Rights Coordinator, who will log results and file complaint for tracking purposes. As resolution is achieved, the process is ended.

   If a resolution was not reached, the supervisor will give the client the name and number of the Area/Clinical Director. The complaint will be directed to the Area Director if it is based on an administrative issue or to the Clinical Director if it is based on a clinical issue. The supervisor will inform the client that the Area/Clinical Director will contact him/her within five working days to further discuss the issue.

B. If a client's problem is unresolved after talking with the supervisor, and the supervisor has given the client the Area/Clinical Director's name/number and has passed the Complaint Form (Parts 1 and 2) to the Area/Clinical Director, the following process will be followed:

1. The Area Director/Clinical Director (or designee) will contact the client within five working days, regarding the complaint.
2. The Area/Clinical Director will listen to the client's concerns and requests for action. The Area/Clinical Director will verify the facts of the situation and evaluate both the employee's and client's points of view.
3. If resolution is achieved, the Client Complaint Forms part 1 and 2 should be forwarded to the Client Rights Coordinator, who will log results and file complaint for tracking purposes. Confirmation of the resolution will be forwarded to the client in writing by the Client Rights Coordinator, ending the process.

   If a resolution was not reached, the client will be directed to the Client Rights Coordinator to file a formal grievance.

ACTIVITY:CLIENTS RIGHTS SUBJECT: COMPLAINT/GRIEVANCE

EFFECTIVE DATE: 05/07/92 AMENDED DATE:10/27/00 NUMBER: 5.00ls

C. Any client may elect to make a complaint directly to the Clients Rights Coordinator to file a formal grievance.

II. **Grievance Process**

A. After meeting with the Area/Clinical Director, if the client continues to feel there is no resolution to the his/her complaint, an appointment should be arranged with the Client Rights Coordinator by the Area/Clinical Director, within five working days.

B. The Client Rights Coordinator shall assist the client in completing the Grievance Form (Attachment C), which will be attached to the completed Client Complaint Form. The Client Rights Coordinator will then arrange for presentation to the Client Rights Committee at the next meeting.

III. The entire complaint/grievance process should not take longer than 45 days.

ATTACHMENTS: Consumer Complaint Form - Attachment A
Follow up - Attachment B
Client Grievance Form - Attachment C

HISTORY NOTE: COA Standards G7.8; G8.01, G8.02, G8.03, G8.04, G8.05. APSM 40-3 Standard 2.12. G.S. 143B-147; APSM 30-1, 14V, Section .0504; 10 NCAC 18L, Section .0400, #.0432. Effective 07/01/84. Amended effective 01/01/92, 10/14/98, 03/17/00, and 10/27/00. MHSCC Policy #5.001s effective 05/07/92. Supersedes MHSCC Policy #1.006 Consumer Rights, and MHSCC Policy #3.006d Client Grievance.

G:\policy\crights\crp&p\grievance

**Attachment A**

TO BE COMPLETED BY CLIENT

**CLIENT COMPLAINT**
**Mental Health Services of Catawba County**

**PART 1**

**CLIENT'S NAME:**

**TELEPHONE #:** _____ **PROGRAM:**

**1) Identify all persons involved:**

**2) Describe the complaint** (be specific, include dates, times and location as appropriate)**:**

**3) Have you discussed this complaint with the staff member involved? ? YES ? NO**
If yes, describe conversation /outcome:

**How can we help you resolve this issue?**

By completing this form, I am filing a formal complaint as described above.

**Client/Guardian Signature** **Date**

**COMMENTS /ACTIONS TAKEN BY STAFF RECEIVING THE COMPLAINT** (please record dates/times of contact with client)**:**

**Signature/Date:**

**FORWARDED TO CLIENT RIGHTS COORDINATOR**: _____(Must be forwarded within 5 days )

**Attachment B**

**TO BE COMPLETED BY STAFF**

**PART 2**
**Follow-up**

**CLIENT'S NAME:**
**PHONE #: _____ PROGRAM:**

**FOLLOW-UP BY SUPERVISOR OF STAFF IDENTIFIED IN COMPLAINT:**

**Received by SUPERVISOR :**
**Contacted by Client:**
**COMMENTS/ACTIONS TAKEN BY SUPERVISOR** (please record dates and time of contact with client):

**DOES THE CLIENT FEEL THIS ISSUE/COMPLAINT HAS BEEN RESOLVED? ? Yes ? No**

**If so, please forward this form to the Client Rights Coordinator.**
**Forwarded:**

**If not, the staff member should give the client the name and number of the Area/Clinical Director and forward the form to the appropriate director.** (*If the complaint is of an administrative nature, it should be forwarded to the Area Director; if the complaint is of a clinical nature, it should be forwarded to the Clinical Director.)*

I agree with the contents of this form:

**Client/Guardian Signature** **Date**

**SUPERVISOR Signature/Date:**

**FORWARDED TO AREA/CLINICAL DIRECTOR:** (if applicable) (Please circle the appropriate director):
_____(Must be forwarded within 5 days )

**CLIENT'S NAME:**
**PHONE #:** _____ **PROGRAM:**

**FOLLOW-UP BY AREA/CLINICAL DIRECTOR:**

**Received by AREA/CLINICAL DIRECTOR:**

**Contacted by Client:**
**COMMENTS/ACTIONS TAKEN BY the Area/Clinical Director** (please record dates and time of contact with client):

**THE CLIENT FEEL THIS ISSUE/COMPLAINT HAS BEEN RESOLVED? ? Yes ? No**

**If so, please forward this form to the Client Rights Coordinator.**

**The staff member should give the client the name and number of the Client Rights Coordinator and advise the Client to contact the Client Rights Coordinator to file a formal Grievance**.

I agree with the contents of this form:

**Client/Guardian Signature** **Date**

**AREA/CLINICAL DIRECTOR Signature/Date:**

**FORWARDED To CLIENT RIGHTS COORDINATOR:**
(to be forwarded within 5 days )

**FOLLOW-UP By CLIENT RIGHTS COORDINATOR:**

**Received by Client Rights Coordinator:**

**Resolution Occurred at: ? Staff level ? Supervisor level ? Area/Clinical Director level**

**Formal Grievance filed? ? YES ? NO IF YES, when**

**Grievance will be heard by Client Rights Committee:**

**Comments:**

**Client Rights Coordinator Signature/Date**:

**FOLLOW-UP/RECOMMENDATIONS of THE CLIENT RIGHTS COMMITTEE:**

**Heard by the Client Right Committee:**

**CLIENT RIGHTS COMMITTEE CHAIRPERSON Signature/ Date:**

**Attachment C**

## CLIENT GRIEVANCE FORM

The Mental Health Services of Catawba County (MHSCC) Board and its contracted agencies have policies in place which will assure that any client receiving services, or their legally responsible guardian, shall have access to proper procedures to address complaints. Complaints by consumers are viewed as a viable source of information, not only to resolve individual client problems, but also to assist in the planning and delivery of services by the area program.

It is important that you have already talked with the people most directly responsible for your treatment: the primary care giver, that person's supervisor, and either the Clinical or Area Director. It is our intention to provide an informal process between you and those facility employees to clarify facts and find possible alternatives. However, if you did not feel that satisfactory alternatives were reached, there are additional steps that you can take to assure that your grievance has been heard.

A Client Rights Committee has been established that is made up of consumers, close relatives of consumers, and Area Board members, none of whom are employed by any MHSCC Program. The committee members have experience with and are representative of the three disability groups: Mental Health, Developmental Disabilities, and Substance Abuse. It is the responsibility of the Client Rights Committee to hear client grievances about the services they are receiving, allegations that client rights may have been violated, in some cases appoint a client advocate, and to be objective in making recommendations for resolutions to the problem. In order for the Client Rights Committee to review the complaint, the following information needs to be completed.

1. Please write a brief explanation of your complaint:

_____

_____

_____

_____

_____
_____

_____

Attach additional sheets if necessary.

2. Please list the staff members with whom you have already addressed your complaint:
_____
_____
_____
_____
_____

3. Please write your name, address and phone number below. The Client Rights Committee Chairperson will be contacting you to set up a meeting date and time.

   Name: _____

   Address: _____

   Phone #: _____

4. Please read and sign the following agreement regarding the release of information to the Client Rights Committee to process your grievance.

   I, _____, hereby authorize Mental Health Services of Catawba County to release Medical Record information regarding the treatment of _____ to the Client Rights Committee, for the purposes of resolving a complaint. I understand that this information is to be used only to help the Client Rights Committee make recommendations regarding my grievance.

   _____ _____
   Client/Guardian Signature Witness Signature

   _____ _____
   Date Date

5. Mail this completed form to: Client Rights Committee Chairperson, Mental Health Services of Catawba County, 3050 11th Avenue Drive, SE, Hickory, NC 28602.

**The Chairperson will be contacting you regarding the Client Rights Committee meeting date and time.**

# Local Business Plan: Strategic Plan Matrix

| | |
|---|---|
| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 3**

**Goal: -There is a description attached of how individual care management (eligibility determination; planning and outcome oversight; plan authorization; health, safety and welfare assurances) will be provided**.
-The plan contains a description, in table format, of the availability of case management services that describes the number and identification of case management providers
-A list of service agreements, memoranda of agreement or contracts with other agencies and systems is attached and ensures that client care is coordinated.
-A policy providing for a choice of support and service coordinators, the LME function and case managers is attached.
-Mechanisms are in place to assure coordination of benefits for Medicaid eligible people needing non-covered services and for people who cycle in and out of Medicaid eligibility. These mechanisms enable individuals to continue receiving needed specialty supports and services without interruption
-A policy governing consumer right to grievance and appeals and a description of the process for review and corrective action.
-A policy requiring that individuals transitioning from one set of services to another will do so supported by a coordinated, consumer-friendly process
**Assurance of the capacity to provide for the array of services when providers within the network will no longer offer services is evident by:**
- A policy is available that accepts responsibility for the continued provision of services in the event of a service provider abandoning the consumer, losing his/her license or other catastrophic event
- A policy statement is evident that directs management to utilize LME funds on a specific time limited basis to ensure continuation of care.
- The LME has contractual language (hold back provisions) with providers that, through financial penalties, discourages disruptions to the provision of care.
**-**A policy that describes how the LME will ensure active and collaborative discharge planning, including Olmstead planning, to facilitate continuity of care for individuals discharged from state hospitals and residential schools.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| First contact through Access begins the process of collecting information regarding a client's Medicaid eligibility and target population criteria. | Assure that all RFP processes and contracting addresses required criteria for all levels of best practices in service delivery (timeliness, oversight, | |

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|---|---|---|
| If necessary, further eligibility determination is made at time of initial face-to-face contact by financial advisor and/or clinician assigned to the case.<br><br>Treatment planning is done by the primary clinician, with the consumer, identifying comprehensive treatment goals and addressing all issues of health, safety and welfare assurances as clinically indicated. Care management currently is a function of the primary clinician. If case management is indicated and provided for in the treatment plan, the primary clinician may serve in that role or an independent case manager is assigned.<br><br>Planning oversight is provided by the clinical supervisor and/or Ph.D./M.D. signing the service order. This includes review of the treatment plan for scope and clinical best practice interventions, as well as targeted outcomes.<br><br>If contract services are requested in treatment planning, the UM process is initiated (see details of process in previous component of this section). UM committee has representation from all disability areas.<br><br>Treatment plans are updated regularly by the primary clinician and consumer, with supervisory oversight, matching interventions to treatment goals and assessing targeted outcomes.<br><br>If upon Access entry, the services requested or indicated need to be referred to an external contract provider, the UM process applies for planning and outcome oversight and plan authorization. | planning review, outcomes, etc.) | |

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| Planning for the LBP includes the provision for case management to be retained as part of the LME. Currently there are 24 case managers on staff, providing services to all disabilities.<br><br>Steps have begun to integrate case management under one level of supervisory oversight; this will result in cross-training case managers as well as their representation of specialty areas, with case management to be retained as a single unit under the LME<br><br>To assure wraparound services and coordinated care for clients, MOAs and contracts with other community providers are in effect (Attachment D)<br><br>Provider network is being developed<br><br>Client choice in all levels of treatment, including provider, have been addressed in multiple policies.(Attachment E) (Attachment B) ( Attachment A) (Attachment F)<br><br>Case management is the primary mechanism in place to assure the coordination of benefits for Medicaid-eligible people needing non-covered services and for people who cycle in and out of Medicaid eligibility. Using information regarding the availability of community services, there are regular collaborative efforts with DSS, Public Health, Cooperative Christian Ministries, Salvation Army, Lutheran services, Catawba Valley Medical Center, and local church charities. In addition, there is an emergency fund in place for consumers who need | Plans for organizational structure of the LME will have a single case-management unit, separated from clinical services to provide a firewall between case management and service delivery.<br><br>Criteria for the assignment of case management services will be developed, consistent with level of care criteria. Matching that criteria with anticipated needs of the target populations will determine the number and type of case managers available. As that is established, a grid will be provided capturing that information.<br><br>LME role in case management assignment and provision will be addressed with all QPN members as the network is established.<br><br>Continue to develop provider network and contracts with other agencies<br><br>Service Management Committee will consistently review policies and procedures to ensure the inclusion and provision for consumer choice. The same standards will apply for the QPN.<br><br>Continue to emphasize this role in case-management unit<br><br>Continue to identify and nurture alternative services for consumers, engaging all supports | The widely differing rules for delivery of case management to the various disability groups makes integration a challenge<br><br>LME doesn't control the money as a result of direct billing of Medicaid by private providers.<br><br>Reluctance/refusal of private providers to provide needed services when funds are not available.<br><br>Lack of free-clinic and other services for individuals with limited ability to pay for service<br><br>Limited funds to place in emergency fund; this money is usually committed by mid-year |

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| services not covered by Medicaid, a Caring and Sharing fund, and sponsorships developed by the Mental Health Fund which is a private non-profit developed to secure funding for needed services to consumers lacking resources. To the capacity of resource availability, these functions enable individuals to continue receiving needed specialty supports and services without interruption.<br><br>Policies and procedures are in place addressing the right for consumer grievance and appeals (Attachment C)<br><br>The provision for all consumer transitions between services to be supported by a coordinated, consumer-friendly process is addressed in all service provision expectations of staff, and supported by policy (Attachment A)<br><br>No policy statement has yet been completed regarding the LME's role in provision of services/care due to a provider's inability to provide services for any reason. Divestiture has been planned to ensure the least disruption of services, and the LME will maintain limited clinical services to service as a "safety net" should consumers be unable to continue or secure services from a provider network; however, funding for this service provision has not been identified.<br><br>Contract language addressing holdback provisions with providers (to discourage disruptions to the provision of care) has been developed and is being reviewed by county legal services. | Will develop policy to incorporate LME role in continuity of service provision and associated funding commitment.<br><br>Implementation of contract language contingent upon legal review and recommendation.<br><br>Continue establishment of solid QPN, maintaining rapport and business partnerships which will foster | This goal is in conflict with the overall purpose of the state redesign plan, which is to require LMEs to completely divest of service provision<br><br>Hold-back provisions may not be legally enforceable, may not be supported by the Division of MH/DD/SAS when providers raise complaints, or may not be practical when enticing providers to work with the LME |

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|---|---|---|
| Active and collaborative discharge planning to facilitate continuity of care for individuals discharged from state hospitals and residential schools (including Olmstead planning) is a well-established practice, backed by policy (Attachment A) MHSCC historically has maintained a low rate of referral to Broughton Hospital and residential schools; current census is 2 clients subject to Olmstead discharge planning from Broughton, and one adolescent from Wilson School. A Broughton Hospital liason actively coordinates and collaborates in discharge planning from the state hospital, and CTSP case managers assume that responsibility with residential school discharges. | commitments to maintaining continuity of care<br><br>Maintain priority of assuring no disruption of services to consumers in every step of divestiture planning and implementation.<br><br>Maintain active attention to community capacity and resource development as it ties to discharge needs of individuals coming back into the community. | There is no assurance the LME will have funding necessary to provide “specific time-limited” services |

**Attachment D – List of Service Agreements, MOAs, and Contracts**
**Attachment E – Draft Consumer Choice Policy**
**Attachment B – Provision of Services Policy**
**Attachment F – Code of Professional Conduct**
**Attachment C – Complaint/ Grievance Procedure**
**Attachment A – Service Coordination Policy**

**List of Service Agreements, MOAs, and Contracts**

Catawba Valley Medical Center
- MOA regarding after-hours emergency services
- MOA for in-hospital consultations provided by area program staff
- Contract for psychiatric services
- Contract for inpatient services for indigent and those requiring detox

Frye Regional Medical Center
- MOA regarding after-hours emergency services
- State contract for substance abuse involuntary commitment services
- Contract for diversion of individuals with MR/DD diagnoses

Flynn Homes
- Contract for halfway house services for substance abusers

Catawba County Government
- MOA with Sheriff's Department
- MOA with Emergency Services
- MOA with Public Health
- MOA and contracts with Social Services

Contract Providers, Private Providers and Direct Enrolled Providers
- Adult Life Program – Adult Day Care, Psychosocial
- Agape Youth and Family Services, Inc. – Residential Level III, Day Treatment
- Alexander Children's Center – Residential Level III, Day Treatment
- Brent Drum – SA Therapy
- Care Group – Residential Level II
- Carolina Caring Connections – Respite, CBS
- Carolina Treatment Associates – Therapy
- CNC, Inc. – CBS, DD Residential
- Community Alternatives of NC – MR/MI Residential, CBS
- Crossroads Counseling Services, Inc.
- Dan Opdyke
- Deaton Investments, LLC – MR/MI Independent Living
- Donald Mott – Psychological Services
- Econoforce – ADVP, Case Management MR/MI
- Eleanor Castleberry
- Ervin Finger – MR/MI Independent Living
- Gene Haas – Therapy
- High Hope of Hickory, Inc. – DD
- Home Care Management – CBS
- Hope Homes, Inc. – Residential Level III, CBS
- James Parrott, M.D.
- Kathy Young-Shugar
- Liberty Corners Enterprises – MR/MI Independent Living
- Life Enrichment Center – Adaptive Skills
- Lynn James-Smith
- New Beginnings Family Service – Residential Level III
- Nova, Inc. – Residential Level III
- Omni Community Service, Inc. – Residential Level II
- Our F.A.T.H.E.R.S. Place, Inc. – Residential Level III
- Pamela Adams
- Paulette Lawrence
- Person-Centered Partnerships, Inc. – CBS
- Positive Choice – Residential Level III
- RHA Health Services, Inc. – ADVP, CBS
- Rigardy Munoz, MD
- Rita Cathey
- Robert Custrini

Sara Shelley
SCW Residential Care, Inc. – Residential Level III
Shook & Tarlton – MR/MI Independent Living
Sipe's Orchard Home – Residential Level III
Supported Living Youth and Family Service – Residential Level II and III
Susan Hurley
Swan Bethel, Inc. – Residential Level III
Three Springs, Inc. – Residential Level III Camp
Timber Ridge Treatment Center, Inc. – Residential Level III Camp
Trisha Miller-Kallenbach
Turning Point Services, Inc. - CBS

DRAFT

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGING ENTITY (LME)

SUBJECT: CONSUMER CHOICE

Number:
Effective Date: 07/01/99
Amended Effective:
Board Approved:
QMT Approved: 10/11/02

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POLICY:

It is the policy of Mental Health Services of Catawba County (MHSCC) to assure that all consumers are informed of community resources and given a choice of providers, services, and supports within a 30-mile/30-minute radius of Catawba County. At no time will agency staff attempt to direct persons toward services provided by MHSCC.

PROCEDURE:

1. The screening clinician will provide each consumer a directory of providers and community supports with a description of the services/resources each provides.

2. The consumer and/or family will select the provider from whom they wish to receive services.

3. In the event the consumer chooses MHSCC as the service provider, the screening clinician will obtain the consumer's signature on the Statement of Consumer Choice.

Attachment: Attachment I – Statement of Consumer Choice.

HISTORY NOTE: Effective and approved 07/01/99. Amended and approved by QMT on 10/11/02. Approved by the Mental Health Board on and effective. **NOTE:** This policy 3.004(f) 3 was originally in the CAP-MR/DD Services of Mental Health Services of Catawba County Policy and Procedure manual. The policy has been amended as of 10/11/02 and can be found in both the LME Policy and Procedure Manual (#) and that of Mental Health Services of Catawba County (3.004(f) 3.

**Attachment I**

**Statement of Consumer Choice**

| |
|---|
| Client Name: Record Number: |
| **MENTAL HEALTH SERVICES OF CATAWBA COUNTY**<br><br>**Statement of Consumer Choice** |
| I understand that I have a right to select my Service Provider. I have received information on the Services Providers and community supports available to me in the area where I live. I also understand that I may change Service Providers at any time, but if possible, a reasonable notice will be given to the Care Coordinator and Services Provider. |
| **I HAVE SELECTED THE FOLLOWING PRIVATE PROVIDER(s):** |
| 1. |
| 2. |
| 3. |
| **I HAVE SELECTED MENTAL HEALTH SERVICES OF CATAWBA COUNTY AS THE SERVICE PROVIDER FOR THE FOLLOWING REASONS:** |
| 1. |
| 2. |
| 3. |
| Client/Guardian Signature: Date: |
| Witness: Date: |

LME\CONSUMERCHOICE

Attachment F- Code of Professional Conduct – Service Management

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

| | |
|---|---|
| ACTIVITY: ADMINISTRATIVE SERVICES | Number: 1.044 |
| | Effective Date: 05/04/00 |
| SUBJECT: CODE OF PROFESSIONAL CONDUCT | Amended Effective: |
| | Board Approved: 05/04/00 |
| | QMT Approved: 04/14/00 |

POLICY:

Mental Health Services of Catawba County (MHSCC) establishes the following Code of Professional Conduct that guides the behavior of all staff members. This Code of Conduct is developed to ensure the highest quality of services, to respect the dignity of the individuals we serve, and to maintain the highest standards of practice in the field. The guiding principles of the Code of Professional Conduct include the ideals of professional competence, personal integrity, responsibility for one's actions, and respect and concern for consumers in all aspects of one's work.

PROCEDURE:

For the purposes of this Code of Professional Conduct, the term "staff member" shall refer to any person employed by MHSCC regardless of job description. A "clinical staff member" is any individual who has direct contact with clients as part of his or her regular duties. The clinical staff include Psychiatrists, Psychologist, Psychological Associates, Social Workers, professional counselors, Substance Abuse Counselors, Case Managers, and other individuals who provide direct services, whether licensed or unlicensed, certified or uncertified.

1. All staff members respect the right of our consumers to have informed consent regarding their participation in our services. Clinical staff members inform consumers of the types of treatment available, the benefits of treatment, and the potential negative effects of treatment. Clinical staff members also inform consumers of treatment options available outside this agency, if appropriate to the needs of the consumer. Consumers are actively included in all decisions made concerning their treatment, care and the types of services provided to them.

2. All staff members respect the right of consumers to refuse participation in treatment, clinical trials, clinical studies and outcome studies or research being conducted by or on behalf of MHSCC.

3. Clinical staff members respect freedom of choice for consumers and seek to offer consumers a variety of options in their treatment plans. Refusal to participate in any program carries no penalty to the consumer other than the potential lack of benefit of that program.

4. All Mental Health staff members respect the right to privacy of our consumers and ensure the confidentiality of information obtained from them. All staff members work to fully implement the confidentiality policies, regulations and laws applicable to their work.

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5. Treatment recommendations made by our clinical staff members are based primarily on diagnostic and treatment needs of the individual served and only secondarily on funding and programmatic issues. When our agency is not able to fully meet the needs of the consumer for whatever reason, the consumer is informed of this and available options are discussed.

6. When necessary, staff members will discuss financial obligations with the consumer and assist the consumer in developing an alternate payment plan. If a consumer needs services beyond the ability to pay for those services, clinical staff members will assist the consumer to use the fee reduction process established by this agency. In all his or her work, a clinical staff member will seek to ensure that a consumer is not overly burdened by the financial requirements of treatment.

7. All staff members make themselves aware of the grievance and complaint processes available to consumers and advise consumers on how to best use this process as needed. Staff members respect the right of the consumer to file a grievance or complaint. A staff member will work diligently to resolve any grievance or complaint filed against him or her.

8. All clinical staff members will familiarize themselves with the code of ethics of their respective professions. Further, clinical staff members are expected to adhere to the code of ethics of their profession regardless of whether they are members of any professional organization. For reference purposes, the relevant codes of ethics for some of the clinical staff are:

   Psychologists and Psychological Associates: American Psychological Association (1992). Ethical Principles of Psychologists and Code of Conduct.

   Social workers and Case managers: National Association of Social workers (1996). Code of Ethics.

   Sexual Abuse Treatment Professionals (regardless of discipline): Association for The Treatment of Sexual Abusers (1997). Ethical Standards and Principles for the Management of Sexual Abusers.

   Substance abuse professionals (regardless of discipline or license): Addiction professionals of North Carolina (undated). Code of Ethics.

   Licensed Professional Counselors: American Counseling Association (April 1995). Code of Ethics and Standards of Practice.

   Nurses: International Council of Nurses (October 1998. Code for Nurses.

   Any practitioner of therapeutic hypnosis, regardless of discipline: American Society of Clinical Hypnosis (July 1998). Code of Ethics (Effective November 16, 1983).

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Marriage and Family Therapists: American Association of Marriage and Family Therapy (July 1, 1998). AAMFT Code of Ethics.

Physicians (M.D. and D.O.)practicing psychiatry or neurology: American Psychiatric Association (1997). Principles of Medical Ethics and Addendum 1: Guidelines for Ethical Practice in Organized Settings.

Anyone administering psychological tests: American Education Research Association, American Psychological Association, and National Council on Measurement in Education. (1986). Standards for Educational and Psychological Testing.

The above list of ethical codes is not to be seen as complete and clinical staff must adhere to the code of ethics for their professional even if not listed in this policy. In some instances, clinical staff must adhere to more than one ethical code. In cases of conflict between ethical codes, the clinical staff member will seek direction from his or her supervisor and/or the Clinical Director as needed. Further, as a profession's code of ethics is updated, the latest version of that code will be used in evaluating the behavior and standards of all clinical staff members.

9. MHSCC specifically prohibits any staff member from accepting payment or any other consideration for referring applicants to a specific provider of services. Furthermore, no staff member shall pay another organization for referring individuals to this agency.

10. Clinical staff members who maintain an independent private practice in addition to their work with this agency are prohibited from referring any individual seen in this agency to their own private practice. Furthermore, no referrals can be made to a clinic, practice or other business in which any staff member has an interest. Exceptions to this provision are made only when there is clearly a compelling reason, it is in the consumer's best interests to make the referral, and no other suitable alternative for the consumer exists. In these instances, the Clinical Director and/or the Area Director must approve such a referral before it is initiated.

11. When a clinical staff member leaves the agency to enter private practice, he or she cannot transfer current consumers to the private practice without the express consent of the Clinical Director or the Area Director. Such consent will be given only when there is clearly a compelling reason and it is clearly in the consumer's best interest to follow the clinical staff member into private practice.

12. No employee of MHSCC may conduct private practice on the premises. All private practice work must be done on other than an employee's work hours and in a setting outside of the facilities of MHSCC.

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13. Clinical staff members will avoid dual relationships that potentially can cause harm to a consumer. If a clinical staff member finds him or herself in a dual relationship with a consumer, the clinical staff member must consult with his or her supervisor. This consultation will examine whether the dual relationship creates either a conflict of interest or a potential for harm to the consumer. When a potentially harmful dual relationship exists, the consumer will be transferred to the caseload of another qualified clinical staff member for services. If this cannot be done, it is the staff member's responsibility to receive ongoing consultation to ensure that the dual relationship does not harm the consumer.

14. All staff members will maintain a professional environment in the workplace. This environment will be free of harassment in any form. In addition, all staff members will conform to all county policies and procedures for appropriate behaviors.

15. Any clinical staff member who is aware of a potential violation of this Code of Professional Conduct is required to discuss such violations with his or her immediate supervisor, with the Clinical Director (concerning clinical matters), or with the Area Director (concerning administrative matters).

All reports of violations of this Code of Conduct will be investigated by the Clinical Director and/or the Area Director in cooperation with the individual's immediate supervisor. In instances where the circumstances warrant, a formal investigation will be coordinated with the Catawba County Personnel Department and possible disciplinary action will be explored.

HISTORY NOTE: Approved by QMT on 04/14/00 and approved by the Mental Health Services Board of Directors on 05/04/00 and effective 05/04/00.

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# Local Business Plan: Strategic Plan Matrix

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|---|---|
| **Area Program(s)/County Program** | Mental Health Services of Catawba County |
| **Contact** | John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov |
| **Submission Date** | 04/01/03 |

**Item: IV. Service Management 4**

**Goal: There is a list of the current best practice approaches, protocols and methods of monitoring best practices for continuous quality improvement for consumers in the target populations established by the state. These include, but are not limited to:**
- Person-centered planning practice.
- Self-determination principles as applied to practice.
- Recovery model philosophy as applied to practice.
- System of care/ supports philosophy as applied to practice.
- Evidence-based prevention practice.
- Evidence-based substance abuse prevention/treatment.

The plan indicates that the LME has knowledge of and is committed to an annual technical assistance plan that trains qualified providers in the current models of best practices.
An annual training plan for all LME staff, consumers and families is evident and incorporates best practice models.

**Effective Date: 10/03**

| Steps Taken | Steps Planned | Barriers |
|---|---|---|
| MHSCC maintains COA accreditation, adhering to standards of care providing the basis for best practices<br><br>The Clinical Guidelines Series for Area Programs, developed by the Division of MH/DD/SA, has been distributed to supervisors for reference and discussion with staff, serving as best practice models in many areas<br><br>Policy reflects agency commitment to best practice | Continue to obtain and research most current standards for evidence-based best practices<br><br>Based on review of services currently provided in different disability areas, identify gaps and begin process of training/implementation on best practice interventions. Enhance supervisory oversight of treatment planning and outcomes<br><br>Continue to plan regular training on best practices issues, per unit or for staff as a whole. Make | Lack of consolidated, easily-referenced information on “best practices” standards per disability. This is a research- and time-intensive undertaking<br><br>Lack of resources to monitor services provided by external providers.<br><br>Lack of funds to bring in presenters from outside the area. Lack of funding for trainings in general. |

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| standards (Attachment G)<br><br>Information from NAMI and MHA on best practices and consumer-focused practices has been shared with staff<br><br>Review of best practices/ research and clinical data from other states and regions<br><br>Trainings on clinical interventions are provided to staff on a regular basis. Staff Trainer and Staff Development team in place to oversee training needs. Joint efforts with DSS in past year to maximize financial resources in developing a clinical training schedule for staff of both agencies<br><br>A review of clinical interventions per disability area is being conducted, identifying those areas/units most closely aligned with best practice expectations identified by the state. Currently have person-centered planning, Clubhouse model, ACT team, ACT program (day program collaborative with three school systems, for children with emotional/behavioral problems), outcome-based substance-abuse prevention efforts in the schools, etc.<br><br>SPMI Program Manager and staff have attended training on Recovery Model and philosophy. Currently developing a training in-house for direct care staff, consumers, and external providers. Have a senior psychologist on staff with expertise and related experience in Recovery Model<br><br>Identified need for more research on best practice models, along with efficient manner of disseminating information to supervisors and staff for practice and | trainings available to external providers. Explore best mechanisms for providing training on best practice approaches to consumers and families, making information accessible and usable from a consumer level rather than clinical orientation.<br><br>Conduct survey of current contract providers around best practices, assessing practice and/or needs for training or technical assistance. Plan response to needs.<br><br>Continue to increase proficiency and scope of best practice implementation, working into mentoring role along with monitoring role of LME<br><br>Address best practice interventions and monitoring in QPN orientation and training, also incorporating into contractual language as indicated. UM/QPN oversight of client outcomes<br><br>Utilize Staff Trainer and Staff Development team, working with Service Management and QPN committee, to identify best practice training needs. Identify topics and presenters of trainings, within resource availability<br><br>Research other available training modes (videos, on-line classes, etc.) which may maximize exposure to concepts by easy accessibility<br><br>Develop an annual training plan for all LME staff, consumers and families | Provision of trainings on a fee per person basis may limit level of involvement by community, consumers, families |

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| oversight in all areas of service.<br><br>Identified need to be not only familiar with best practices in theory, but actively practicing and monitoring as this role of oversight will be shifted to include QPN service providers. This need is also imperative in expanding RFP attractiveness as divestiture planning is implemented<br><br>QPN Technical Assistance Protocol in place to address LME's commitment to support for QPN providers, including training regarding best practice models (Attachment H) | | |

| **Reviewers Comments:** |
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**Attachment G – Clinical Best Practices Policy**
**Attachment H – QPN Technical Assistance Protocol**

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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| ACTIVITY: CLINICAL SERVICES | Number: | 3.002(a) 7 |
| | Effective Date: | 09/19/02 |
| SUBJECT: CLINICAL BEST PRACTICES | Amended Date: | |
| | Board Approved: | 09/19/02 |
| | QMT Approved: | 09/13/02 |

POLICY:

It shall be the policy of Mental Health Services of Catawba County (MHSCC) to adopt nationally recognized evidence-based models of clinical best practices to meet the needs of our consumers.

PURPOSE:

By adopting clinical best practice models MHSCC will attempt to demonstrate which services work for our consumers and which services do not.

BEST PRACTICES DEFINITION:

Interventions, treatments, services or actions that have been shown to generate the best outcomes or results. The terms “evidence-based” or “research-based” may also be used.

PROCEDURE:

The Clinical Director, Program Managers will review service delivery needs and individual outcomes related to consumers on an on-going basis. The Clinical Director and Program Managers will determine the service delivery models to be implemented according to consumer needs. All clinical staff will educate themselves with models of best practice and work with providers to implement best practice models. Training and technical assistance will be given on an on-going basis to clinical staff and providers as best practice information is or becomes available. Models of best practice that are identified to produce results will be embraced and used for our consumers and models that are identified as not producing positive consumer outcomes will not be supported and used.

HISTORY NOTE: Approved by QMT 0n 09/13/02. Approved by the Mental Health Board on 9/19/02 and effective on 9/19/02.

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**Qualified Provider Network**
**Technical Assistance Protocol**

This document was developed as a means to communicate to our qualified provider network about any technical assistance needs they may have and can request from Mental Health Services of Catawba County (MHSCC).

PROTOCOL:

The Qualified Provider will make a written request to the Area Director of MHSCC requesting technical assistance. This written request should include the problem area(s) for which the provider needs technical assistance (TA) from MHSCC and the name, address and telephone number of the person making the TA request. The Area Director will contact the qualified provider and negotiate a TA date(s) and a TA rate for the time required providing technical assistance.

Technical assistance may be requested in the following areas:

Billing
Client Rights
Documentation
HIPAA
Medical Records
MIS
Outcomes
Quality Assurance
Quality Improvement
State Standards
Staff Training
Other (Need to specify)

Providers need to send written TA requests to:

John M. Hardy, Area Director
Mental Health Services of Catawba County
3050 11th Avenue Drive, SE
Hickory, NC 28602
(828) 695-5900
(828) 695-4256

NOTE: Agency expectations and agency business requirements/practices thoroughly covered in our annual provider orientation are not considered technical assistance and have no charge.

HISTORY NOTE: Approved by QMT on 09/13/02.

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